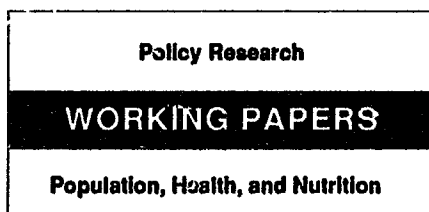


WPS 1053

Population and Human Resources
Department
The World Bank
December 1992
WPS 1053

Development of the Zimbabwe Family Planning Program

Alex F. Zinanga

A serious national family planning effort began after independence in 1980. As a result, the contraceptive prevalence rate increased from about 14 percent in 1982 to 43 percent in 1988. But program efforts are now stalling.

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WPS 1053

This paper — a product of the Population Policy and Advisory Service, Population and Human Resources Department — is part of a larger effort in the department to understand the impediments to contraceptive use in different environments. The study was funded by the Bank's Research Support Budget under research project "Impediments to Contraceptive Use in Different Environments" (RPO 675-72). Copies of the paper are available free from the World Bank, 1818 H Street NW, Washington, DC 20433. Please contact Otilia Nadora, room S6-065, extension 31091 (December 1992, 13 pages).

Family planning was introduced in Zimbabwe as a voluntary movement in the 1950s. Volunteers formed a Family Planning Association in the mid-1960s. The government became interested in family planning in the late 1960s after analysis of the 1961 population census. It gave the Family Planning Association an annual grant, allowed contraceptives to be available through Ministry of Health facilities, and allowed nonmedical personnel to initiate and resupply family planning clients with condoms and pills. But before Zimbabwe achieved independence in 1980, family planning was viewed with great suspicion by the black majority, so the program's effectiveness was limited to the urban few.

A new era began after independence. The new government took over the Family Planning Association and changed its outlook completely. Through government and international donor support, the family planning program was restructured and expanded. The number of family planning personnel more than doubled in some units. More service delivery points were set up — particularly in rural areas. And the information, education, and communication and evaluation and research units were established. Through a World Bank-assisted project (with grant funding from Norway and Denmark), the Ministry of Health began strengthening its family planning capabilities.

These efforts helped increase the contraceptive prevalence rate from about 14 percent in 1982 to 43 percent in 1988. But the program's growth is beginning to stall. More effort and resources are needed if the program is to grow or even maintain its present status. Particularly important are the following:

- Designing innovative strategies to reach hard-to-reach populations.
- Giving more emphasis to information, education, and communication, especially for men and youths, using multimedia.
- Involving other sectors in the delivery of family planning services.
- Broadening the mix of contraceptive methods (especially promoting long-term and permanent methods).
- Making use of alternative family planning delivery systems, such as the use of depot holders, volunteers, and government extension workers.
- Establishing a national population policy.
- Considering cost recovery and other measures for self-sustainment and program growth.

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DEVELOPMENT OF THE ZIMBABWE FAMILY PLANNING PROGRAM

by

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Table of Contents

1. INTRODUCTION	1
2. HISTORY OF THE ZIMBABWE FAMILY PLANNING PROGRAMME	1
2.1. LAWS ON FAMILY PLANNING	3
2.2. EVOLUTION OF A POPULATION POLICY	4
3. ACCESS TO FAMILY PLANNING SERVICES	5
3.1. PUBLIC SECTOR SOURCES OF FAMILY PLANNING	6
3.1.1. Zimbabwe National Family Planning Council	6
3.1.2. Ministry of Health and Municipal Clinics	9
3.2. PRIVATE SECTOR	10
3.3. METHODS PROMOTED	10
3.4. ELIGIBILITY FOR SERVICES	11
4. FUTURE DIRECTIONS	11
4.1. RESOURCE CONSTRAINTS	12
5. CONCLUSION	12
6. BIBLIOGRAPHY	13

DEVELOPMENT OF THE ZIMBABWE FAMILY PLANNING PROGRAM

1. INTRODUCTION

Zimbabwe lies in the south eastern part of sub-Saharan Africa between the equator and the tropic of Capricorn. It is a fairly small country with a total area of about 391 thousand square kilometers and an estimated population of 10 million in 1990. The country's population growth rate is estimated to be around 3 percent per annum.¹ Because of current and recent high fertility, low and still declining mortality, Zimbabwe has a youthful population with over 50 percent of the population being under the age of sixteen years.

Traditionally, Zimbabweans are pronatalistic with a preference for male children. In the past, many children were important for social prestige, cheap labour in the home and fields, and to compensate for the high infant and childhood mortality. However, despite these pronatalistic tendencies, pre-industrial Zimbabweans practiced family planning primarily for spacing births. Thus, family planning or child spacing is not a new concept in Zimbabwe. Traditionally women spaced their children and birth intervals of eighteen to thirty-six months were the norm. Mothers who got pregnant too early were usually castigated by society. Various traditional family planning methods and practices were used for spacing births. These included breastfeeding for period of up to twenty-four months, postnatal abstinence for long periods, polygamy, coitus interruptus and the use of medicinal herbs.

With urbanization, the situation has now changed, most traditional practices are no longer followed. The demand for efficient modern methods of family planning is high.

Provision of modern family planning information and services was introduced in the country in 1953 when individual volunteers started to work in white communities of the major urban areas. The first family planning clinic for whites was opened by the Salisbury volunteers in Waterfalls on a white suburb just outside Harare. In 1965 the various voluntary groups in the country amalgamated to form the Family Planning Association of Rhodesia which was registered as a welfare organization and affiliated to International Planned Parenthood Federation.

One of the white volunteers Paddy Spilhaus introduced Family Planning services among the black communities of Harare. In 1959 the Ministry of Health allowed her and a few nurses to operate a family planning clinic at Harare Central Hospital outpatients department. She also provided services to communities around the city of Harare through mobile clinics. Following the 1961/62 national census which put the annual rate of increase of the black population at 3.5 percent, the Government became more interested in the activities of the Family Planning Association. In 1967, the Ministry of Health donated a piece of land to Paddy Spilhaus who built a family planning clinic using her own money. Today this clinic has grown to house ZNFPC's headquarters as well.

2. HISTORY OF THE ZIMBABWE FAMILY PLANNING PROGRAMME

The Secretary of Health became a member of the Board of Directors of the Association, the government gave a small grant annually to the Association, and from 1967 the Ministry of Health allowed contraceptives to be made available at all government health institutions.

¹Central Statistical Office of Zimbabwe

The 1970s saw an increase in the number of facilities providing family planning services. The FPs opened several clinics throughout urban areas of Zimbabwe, more Ministry of Health institutions were providing family planning services, the private sector was also actively involved in family planning provision by giving the Association grants or facilities where they could provide family planning services. Commercial farmers were also involved and assisted in building clinics in the commercial farming areas where family planning services could be provided. A scheme where farmers' wives provided contraceptive services to workers on their farms, was also instituted.

To increase family planning coverage of the FPA introduced mobile clinics to underserved areas in 1973, a group of lay men and women were recruited to motivate and educate people in different communities in family planning issues. Because of the success of this educational/motivational project in 1976 the government agreed to allow the Association motivators to distribute contraceptives.²

During the latter part of the 1970s, the Association was given the responsibilities of procuring and distributing contraceptives to the public sector and also of collecting family planning data from all providers of family planning services.

Zimbabwe gained its independence from Britain in 1980 after a protracted sixteen years liberation war. The new Government made major policy changes to address some imbalances in the health sector. In 1981, the Ministry of Health adopted the Primary Health Care concept. Soon after, a Maternal Child Health/Family Planning (MCH/FP) Unit was established in the Ministry itself. The government also directed all MCH/FP units and rural health centers to provide family planning services as an integral part of their MCH services.

To be able to effectively integrate the family planning programme into the Primary Health Care approach and national development initiatives, the government took over the running of the Family Planning Association in September 1981. According to the National Development Plan, 1981-1985 Zimbabwe was

"committed to the Primary Health Care concept and Family Planning should be part of the Maternal and Child Health programme. Family Planning should be tackled as a developmental package which aims at raising the socio-economic conditions of all Zimbabweans."

The Family Planning Association was placed under the Ministry of Health and in protest, the entire white management body resigned. An all black but inexperienced management team (both senior and middle management) was appointed to run the family planning programme.

The task of reestablishing the programme was no mean task. The family planning programme had to be consolidated and integrated into both MCH and development. This was made more difficult by the fact that during the war of liberation, the now ruling party had been vehemently against family planning accusing the then government and the Association of the genocide. Both the white government and the FAP have promoted family planning aggressively among the Black population to arrest what they termed an alarming growth rate among the

²The motivators were allowed to distribute oral pills and condoms only.

African population, but at the same time encouraging whites to emigrate into the country. The Association and some health institutions had also used injectables and female tubal ligations without individuals' knowledge or consent in some cases.

The new government went through a process of changing the image of the Family Planning programme to put it in line with the aspirations of the people. The Ministry of Health changed the name of the Family Planning Association first to the Child Spacing and Fertility Association (CSFA)³, then to Child Spacing and Family Planning Association (CFSPA)⁴, yet changed again to Child Spacing and Family Planning Council (CFSPC), and finally to the Zimbabwe National Family Planning Council (ZNFPC) in 1984.

During the same time, the programme went through a substantial growth period both in terms of increasing the numbers of staff, particularly the Community Based Distribution and the Youth Advisory Units which more than doubled. New units were set up namely the Information Education and Communication (IEC) and the Evaluation and Research (ERU) Units. Both senior and middle management had to undergo crash programme management courses.

2.1. LAWS ON FAMILY PLANNING

The Zimbabwe National Family Planning Council Act of 1985 set up the Zimbabwe National Family Planning Council as a parastatal in the Ministry of Health. Under this Act of Parliament, ZNFPC was given the responsibility to

- a) coordinate provision of family planning information and services in Zimbabwe;
- b) provide facilities for the delivering of child spacing/family planning services, investigate and treat infertile couples, provide voluntary surgical contraception procedures and cytology services;
- c) implement Primary Health Care and other community development activities related to family planning;
- d) conduct research in reproductive health and effects of contraceptives on the health of users;
- e) diagnose and treat sexually transmitted diseases and cancer of the cervix and breast; and
- f) encourage, foster and promote family planning.

Besides this Act of Parliament, there are a number of laws and Ministry of Health policies in place which encourage and promote family planning use in Zimbabwe. Free Health

³Child spacing and assistance to infertile couples was stressed and family planning was not talked about.

⁴Family planning was then slowly reintroduced.

Care for those earning less than \$150.00 per month introduced in 1980 removed one of the major barriers to contraceptive use. In 1984 it was noted that the abolition of fees for the low income section of the community

"made family planning services more accessible to the majority of our people and consequently the number of acceptors has increased three fold in just over three years."

Also important in increasing the accessibility of family planning services was the adoption of the Primary Health Care concept resulting in many rural health centers being built and the provision family planning services in the so called "supermarket approach." Family Planning commodities are controlled through the Drug Control Council which registers all drugs to be used in Zimbabwe under the Drugs and Allied Substances Act of 1975.⁵ Injectables and oral contraceptives are Prescription Preparations which means that they can only be supplied on a prescription given by a qualified and registered medical practitioner. However, oral contraceptives are further qualified within the group and put in a special schedule (PP 10). This qualification means that a patient only needs prescription once, and can be resupplied on the initial prescription as often as the patient desires. In 1976 the government gave permission to the then FPA to use lay personnel in the initiation and resupply of oral contraceptives. This policy has increased the availability and accessibility of contraceptives to the rural population who constitute almost 76% of the population.

With the age of consent legally put at 16 years and the legal age of majority at 18 years, women do not need their spouse's consent before getting family planning services.

2.2. EVOLUTION OF A POPULATION POLICY

Zimbabwe does not have an explicit National Population Policy. However, there are a number of initiatives, laws and policies enacted both before and after independence which tend to be pronatalistic. For example:

- a) Taxation Action allows individuals to claim for tax rebates for their minor child up to a maximum of six children.
- b) Paid maternity leave- although only three leaves are allowed per employment period, theoretically one can have more than three leaves if one changes employers.
- c) Free primary education.
- d) Heavily subsidized maternity fees.
- e) Age of Consent or legal age at marriage is too low at sixteen. Someone who starts childbearing at this early age can have a very large family even if the births are well spaced.

⁵Government Notice 884 of 1975.

A number of laws and policies have also been changed to facilitate womens' advancement in Zimbabwe. Of note are the Legal Age of Majority, Equal Opportunities in Employment, Equal Pay for Same Job and the Adult Literacy drive. However, this is being hampered by the legal dualism currently in place in Zimbabwe. Black women are still governed by both the Roman Dutch and Common Law and the Customary or Traditional Law. As a result women, fail to exercise their legal rights because of socio-cultural attitudes and practices of society and their lack of education or lack of support from their partners. And the situation is made worse by their total involvement in domestic roles.

Efforts to establish a National Population Policy started in 1984 and are now at an advanced stage. They have been as follows:

- a) In 1984 the ruling Zimbabwe African National Union (Patriotic Front) Party (ZANU (FP) Congress directed the Zimbabwe National Family Planning Council to mount a child spacing campaign to ensure a reduction in the population growth rate.
- b) In response to the directives, the Zimbabwe National Board of Family Planning set up an expert task force to look into the National Population Policy Issue. In 1987 the Board submitted its recommendations to the Minister of Health for forwarding to Cabinet.
- c) In 1985 Prime Minister Robert Mugabe signed the World Leaders' statement on Population Stabilization.
- d) Following Zimbabwe's participation at the African Parliamentarian Meeting on Population and Development in 1986, a Parliamentarian Select Committee on Population and Development was established. This committee in 1987 ran seminars on population and development for policy makers in all regions of the country. The committee has also submitted its recommendations on population policy development besides playing an advocacy role calling for governmental and national action to address issues of rapid population growth.

As a result of these and other initiatives, the government, through the Ministry of Health, formed an interim Population Policy Secretariat to coordinate the drafting and structuring of an official population policy.

Meanwhile President Robert Mugabe and other senior government officials have made supportive statements on family planning and population at various fora. At the International Forum on Population in the Twenty-First Century (Amsterdam 1989), President Mugabe in his key note address declared that:

"We remain determined in our efforts to establish and maintain a population growth rate that correlates with our economic growth rate within the shortest possible time."

3. ACCESS TO FAMILY PLANNING SERVICES

Family Planning services in Zimbabwe are provided by both the public and private sector. The public sector dominates. The main providers of family planning information and

services are the Zimbabwe National Family Planning Council's Community Based Distributors and Clinics, the Ministry of Health hospitals, clinics and rural health centers, Municipality clinics and private physicians and pharmacies. According to the 1988 Demographic and Health Survey, 24 percent of current family planning users got their supplies from ZNFPC Community Based Distributors, 13 percent from ZNFPC static and mobile clinics, 59 percent from the Ministry of Health and Municipal clinics combined. Only 4 percent of users got their supplies from private physicians and pharmacies.

3.1. PUBLIC SECTOR SOURCES OF FAMILY PLANNING

3.1.1. Zimbabwe National Family Planning Council

The Zimbabwe National Family Planning Council is a parastatal organization under the Ministry of Health. ZNFPC is responsible for the coordination and implementation of family planning in Zimbabwe. The Council's mandate includes providing technical support and quality control for all public and private family planning services, training of family planning providers, conducting media campaigns and routine Information Education and Communication (IEC), advising youths and young adults on responsible parenthood, conducting relevant research and procuring and storing virtually all contraceptives used in the country.

These services are provided through six interdependent units. Although the services are directed at national level the actual implementation is carried out at provincial right down to village level by ZNFPC's team of fieldworkers. The six units comprise of three service units- the Community Based Distribution, Medical/Clinical, and Youth Advisory Services Units, and three support units- the Information Education and Communication, Evaluation and Research and Training Units.

a) The Community Based Distribution Unit

The Community Based Distribution (CBD) programme began in 1976. It is ZNFPC's principal means of outreach. The programme is community oriented and based. CBD workers are selected by the communities which they will serve under the guidance of the Ministry of Community Development and Women's Affairs. They are selected under criteria that require that they be mature (age between 25 and 40 years), literate (at least 7 years of primary education) and of high standing in their communities as well as that they successfully undergo a six week training in family planning, primary health care and interpersonal communication.

After successfully completing the six week training the CBD worker becomes a full time employee of ZNFPC and is deployed in his or her community. The CBD is equipped with the following:

- i) a bicycle;
- ii) oral contraceptives;
- iii) condoms;

- iv) record books and forms;
- v) a procedure manual;
- vi) a screening checklist;
- vii) a variety of IEC materials

A few of the CBDs are also equipped with blood pressure taking machines. The functions of the CBD are to motivate, educate, initiate and resupply contraceptives. Clients are also referred to local clinics for medical examination after once cycle, clinic based methods and management of side effect and complications.

Each CBD worker covers a geographical area of between 15 and 20 kilometers in radius on a bicycle visiting clients at their homes. The CBD workers uses a three week/three months work programme which means that each acceptor is able to see her CBD at least once a month. The programme now has a total establishment of 745 comprising of a Chief of CBD at the national level, 8 Senior Educators at the provincial level, 68 Group Leaders at the district level and 668 CBDs at the community level. Current estimates put the programme coverage at some 30 percent of the rural population.⁶ In 1984, 24 percent of total users of modern family planning methods and 42 percent of rural family planning users obtained their contraceptives from the CBD programme.

b) Youth Advisory Services Unit

The Youth Advisory Services (YAS programme began in 1978 when the Ministry of Education requested the Family Planning Association to provide Family Life Education (FLE) in schools as part of a national effort to deal with the increasingly significant problem of teenage pregnancy among school age girls. At present their unit educates and counsels youth between the ages of 10 and 25 years both in and out of school mainly providing education sessions at primary and secondary schools. In addition, counselling is provided at all of the eight provincial centers at the Youth Center in Harare.

A Parent Education Programme (PEP) has now been added to the programme to complement the Family Life Education. Through the PEP parents are educated on how to communicate with their adolescent children and how to handle common problems which occur during the adolescent period.

A variety of education materials have been produced by the unit, including Human Sexuality Manual, a booklet "Facts About Growing Up," a flipchart, a village television programme and posters which are used in both FLE and PEP sessions and also distributed to youths and parents. A weekly radio programme for youths has also been broadcast.

Currently the YAS Unit has a total staff establishment of 32 Youth Advisors

⁶ZNFPC- CBD Catchment Area Survey, 1988.

operating at provincial levels. Demand for youth advisory services has now outgrown the capabilities of the unit although Youth Advisors only visit schools and institutions at the invitation of school or institutional heads. Efforts are now underway to collaborate with other organizations which deal with youths, in particular the Ministries of Education, Youth and Political Affairs.

c) Medical/Clinical Unit

The Medical/Clinical Unit is responsible for delivering family planning services through thirty static and five mobile clinics. The static clinics are located mainly in urban and peri-urban areas. Family planning services are provided by medically trained personnel.

A variety of family planning services including counselling for all modern methods of family planning, initiation of all methods, and management of problems and complications are offered. Counselling for voluntary surgical contraception is provided at all clinics but VSC services are only provided at Spilhaus Clinic in Harare and Lister House clinic in Bulawayo. Also provided at the clinics are support services such as counselling and management of infertile couples, pregnancy testing, diagnosis and treatment of sexually transmitted diseases, and screening for breast and cervical cancers. These clinics are also used for the practical training of family planning trainings and student nurses during their rural attachments. According to the 1988 Zimbabwe Demographic and Health Survey, ZNFPC clinics serve 13 percent of all users of modern family planning methods. *[For they are also provided in a small number of 9 MOH hospitals].*

d) Information, Education and Communication

The IEC Unit of the Council was established in 1982 to provide appropriate family planning information to the general public, family planning service providers and opinion leaders. The target groups have been segmented and target-specific message developed. A multi-media approach has been used- print materials, mass media interpersonal communication and press and public relations. An Audio Visual Unit was constructed and completed in 1989 which produces electronic, sound and graphic IEC materials.

A number of videos and radio programmes have been produced at this unit. Print materials are contracted out but the Unit has been able to produce a variety of posters, booklets, pamphlets and flipcharts for both clients and service providers.

e) Training Unit

Formal training in family planning in Zimbabwe started in the 1970s. Before then, training was conducted on an ad hoc basis. Now the ZNFPC Training Unit is a well organized and highly professional unit with thirteen staff (one Chief Training Officer, 2 principal tutors, 2 senior tutors and eight tutors) in two centers, Harare and Bulawayo. It conducts four formal courses as well as in-service training for all family planning service providers. The four courses are:

1. A four week course for medically trained personnel on delivery of all contraceptive methods, management of side effects, management of maternal and child health/family planning (MCH/FP) clinics and population education. Around 200 trainees are trained at the two centers a year.
2. A three week practical course for IUD Insertion. This course is offered to graduates of a Family Planning Clinical Skills course.
3. A four week course for training of trainers.
4. A six week course for Community Based Distributors (who have no basic medical training) which covers communication skills, contraceptive methods and population education.

Regular in-service courses are also conducted for all service providers. In addition the Unit has developed a number of educational materials and assisted the Ministry of Health in integrating family planning into the curricula of the General Nursing and Midwifery courses as well as setting up family planning training in all of the eight provinces.

f) Evaluation and Research Unit

The Evaluation and Research Unit (ERU) was established in 1984 with technical assistance from San Diego State University. The unit is staffed by four Research Officers, a Resident Advisor and two support staff. It has succeeded in developing data collection system to monitor the council's programmes. Through the quarterly reporting system, the Council is kept up to date on stock levels and service statistics from all provinces of family planning services.

The Unit has established an inventory of health centers delivering family planning services and an inventory model for contraceptive distribution. As a result, reliable statistics on CBDs and Clinics performance are available. Analysis of FP services provided by institutions other than ZNFPC facilities using National Health Information System forms is also done but these data are not very accurate because of the irregularity in receiving these returns.

The ERU has also carried out a number of studies and surveys relevant in developing strategies for the programme as well as collaborating in such studies as the 1984 Zimbabwe Reproductive Survey and the 1988 demographic and Health Survey. A Family Planning/Population Library has been established at Spilhaus. Almost a thousand topics from Zimbabwe and internationally have been collected. In addition the library is connected to POPLINE. The library has proved to be invaluable to family planning and research.

3.1.2. Ministry of Health and Municipal Clinics

In 1981 the government of Zimbabwe adopted the primary Health Care Approach. Family Planning had to be provided as an integral part of Maternal and Child Health. Numerous health care facilities were constructed in rural areas of the country. There are now some two thousand health care facilities (hospitals, clinics and rural health

centers) run by the Ministry of Health, Church groups and local authorities providing family planning services in Zimbabwe. However, the majority of rural health centers are manned by personnel not trained in family planning. At these facilities, health workers use the Community Based Distributors' Checklist before initiation or resupply of a method.

Although a number of family planning services are provided, the major method provided is the oral pill. Voluntary surgical contraception although on a very limited scale is provided at central, provincial and district hospitals. This is usually provided in the postpartum period together with Caesarean sections.

These health facilities also offer a back-up service for the CBD programme by doing initial medical examinations on the CBD clients and management of problems from these clients. Municipal health facilities are also used as family planning practical training centers by the Training Unit of the ZNFPC.

3.2. PRIVATE SECTOR

The private sector in Zimbabwe is very limited and accounted for only four percent of the family planning services delivered in Zimbabwe in 1988. This sector is also urban based and services are provided by a thousand private physicians and one hundred and fifty pharmacies. A wide range of family planning services are offered and the cost of the services vary from fifty cents for one condom, ten Zimbabwe dollars for a cycle of oral pills to one thousand Zimbabwe dollars for a sterilization. The potential of the private sector in family planning provision is not yet fully realized because of unavailability of family planning commodities in this sector. The donor supported Contraceptive Social Marketing programme has alleviated this condition though to a limited extent.

From 1987, Zimbabwe has tried to encourage private sector participation in family planning through the support of a number of private family planning projects such as encouraging Medical Aid Societies to reimburse for family planning service and workplace based family planning services. Some projects have included clinics, community based distribution and contraceptive depot holders.

3.3. METHODS PROMOTED

Following the withdrawal of depo-provera from the programme in 1981 by the government, most clients switched to oral pills. As a result, by 1984 almost 90 percent of modern contraceptive users were on the pill. By 1988 the situation had slightly changed with 86 percent of modern contraceptive users being on the oral pill.

Attempts are now underway to introduce and promote long term and permanent methods of contraception. Information, Education and Communication efforts to promote the use of Intra-Uterine Device (IUD) and Voluntary Surgical Contraception have been launched. Training of personnel in VSC counselling and IUD insertion skills and Voluntary Surgical Contraception techniques have been intensified. In the near future there are plans to introduce implants in the programme. [*Depo-provera is being reintroduced*].

3.4. ELIGIBILITY FOR SERVICES

In the public sector family planning services are readily available to all women of reproductive age. From 1981 several policies have been put in place to remove barriers to family planning provision. Services are now available to all women aged sixteen years and above. Free health services including family planning are available to the unemployed who earn less than Zimbabwe \$150.00 per month. The government also heavily subsidizes both family planning services and commodities to those paying for them. Most commodities are available to the public at below cost price, such as condoms are free, one cycle of oral pills cost between twenty and forty Zimbabwe cents and intrauterine devices two Zimbabwe dollars only.

Despite the lack of legislation on Voluntary Surgical Contraception, in the public sector Voluntary Surgical Contraception is not readily accessible. Some institutions require the husband or male relation's consent and the head of the institution's signature before the service is offered. However, this situation is being reviewed.

4. FUTURE DIRECTIONS

Awareness and approval of modern family planning is fairly high in Zimbabwe especially among married women of reproductive age. According to the 1988 Demographic and Health Survey, 96 percent of all women know at least one modern method. The most known modern method is the oral pill followed by the condom, injectable, IUD and female sterilization. Over 90 percent of women in Zimbabwe also know a source for family planning services. Accessibility of modern family planning methods in terms of distance from providers is not perceived as a problem in Zimbabwe with almost all rural women reporting that they live less than thirty minutes from their nearest source. Almost a third of the women also report that they are visited at their homes by the Community Based Distributors.

However, despite these apparent high levels of knowledge, awareness and approval of family planning, contraceptive prevalence rate for modern methods is only 36 percent. Thus one of the challenges for the future is to research into reasons why women are not using modern methods of family planning despite the level of knowledge. Some of the possible reasons identified so far are:

- i) The limited range of methods available in the programme. With the contraceptive prevalence rate for modern methods at 36 percent, 31 percent of the women are on the oral pill, while only 2 percent or less are using female sterilization, Intra-Uterine Devices, injectables or condoms. Male sterilization is hardly provided because of cultural reasons.
- ii) Husbands' attitude towards family planning methods. Fifteen percent of married women perceive their husbands as against the use of modern family planning methods. However, according to research done in Zimbabwe the major problem is one of lack or inadequate information on family planning on the part of males.
- iii) There are still some myths and misconceptions about most of the modern methods.

As a result future strategies include intensifying IEC efforts using multi-media approaches, targeting specifically males and youths with family planning information, promoting the use of long term and permanent methods of family planning. Faced with dwindling resources, efforts are also underway to test and try other cheaper family planning delivery systems such as the use of depot holders and volunteers and also to involve other sectors in family planning and population. Several government ministries will be approached for collaboration. The Ministries of Information, Community Development, and Lands, Agriculture and Resettlement can potentially reach many potential clients with family planning/population information through mobile cinemas and their extension services while some Non-Governmental Organizations and Ministries of Education and Youth can reach youths in and out of school with family planning/youth advisory information.

4.1. RESOURCE CONSTRAINTS

a) Financial Constraints

Over the last few years financial resources available for social services including family planning have not been very forth-coming both nationally and internationally. Zimbabwe is currently going through economically difficult times due to persistent droughts, the low prices of its exports and the world recession. This has led to lack of increase in the government grants to the family planning programme. Internationally financial resources available for family planning have started to dwindle. However at the same time demand for family planning has increased at a very fast rate.

b) Unavailability of Foreign Currency

The shortage of foreign currency has made it difficult for the programme to procure contraceptives, equipment, motor vehicles, motor vehicle spare parts and educational materials. Unavailability of contraceptives in the private sector has limited the expansion of this sector. Supervision of the ZNFPC programmes has also been crippled by the lack of vehicles.

c) Personnel and Facilities

Zimbabwe is short of medical personnel especially in the rural areas. Staff attrition rates are also very high in the rural areas because of unfavorable working conditions. There is also a shortage of trained manpower especially in the field of family planning. Most health workers are still weak in their information, education and communication and IUD insertion skills.

Most facilities do not offer long term methods of family planning such as IUD's and Voluntary Surgical Contraception for a variety of reasons ranging from lack of trained personnel to lack of equipment and appropriate space.

5. CONCLUSION

Family Planning in Zimbabwe was introduced in the 1950s as a voluntary movement. These volunteers formed an Association in the mid sixties. Government's interest in family

planning started in the late sixties following analysis of the 1961 population census. In its efforts to support and promote family planning the government gave the Family Planning Association an annual grant, allowed contraceptives to be available through Ministry of Health Facilities and allowed non-medical personnel to initiate and resupply family planning clients with oral pills and condoms. However, before Zimbabwe's independence in 1980, family planning was viewed with great suspicion by the Black majority and thus the programme's effectiveness was rather limited to the urban few.

After independence in 1980, a new era was begun. The new government took over the Family Planning Association and changed its outlook completely. Through government and international donor support, the family planning programme was restructured and expanded. Personnel to provide family planning services were more than doubled in the CBD and Youth Advisory Service Units, more service delivery points were set up particularly in the rural areas and new units, the I.E.C. and Evaluation and Research Units were established. Through a World Bank assisted project (with grant funding from Norway and Denmark), the Ministry of Health has also started to strengthen its family planning provision capabilities.

All these efforts have led to an increase in the contraceptive prevalence rate from an estimate 14 percent in 1982 to 43 percent in 1988. However, it is now apparent that the programme's growth is beginning to stall. Much more effort and resources are going to be required if the programme is to grow or even maintain its present status. Future challenges and opportunities will have to include: designing new innovative strategies to reach the hard to reach population, more emphasis on IEC particularly for males and youths using multimedia approach, involvement of other sectors in family planning information and service delivery, broadening the contraceptive method mix particularly; the promotion of long term and permanent methods of contraception, alternative family planning delivery systems such as the use of depot holders, volunteers and government extension workers, and the establishment of a National Population Policy. Cost recovery and other self sustainability measures will also be considered for programme growth. Zimbabwe still remains committed to making family planning services readily accessible to all the people throughout the country.

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